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DIAGNOSIS OF A CASE OF UTERINE MALFORMATION WITH KIDNEY AGENESIS

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THE normal uterus is formed by fusion of the lower segments of the two mullerian ducts. The upper ununited portions of the ducts become the fallopian tubes.

The mullerian duct of each side has a common origin with the kidney of that side. They both arise from the early embryonic tissue,—the mesonephros or wolffian body. This mode of development explains why malformations of the uterus and kidney sometimes occur simultaneously.

Deformities of uterine structure may result from improper or incomplete union of the lower segments of the ducts. The types thus formed are the arcuate, the septate, (partial or complete), the bicornate, and the double uterus, (uterus didelphys). This last named group is caused by the side by side development of the uterine canals instead of by mutual fusion. The term used for this group namely, "double uterus," is often used in a more general sense. It is frequently descriptive of any uterine malformation with two cavities such as the septate or the bicornate type. The two cavities may be more or less separate and each more or less capable of containing the products of conception in event of pregnancy. This type of uterus may have each side equally or unequally developed, and may or may not have a duplication of the cervix and/or the vagina.

The other main reason for uterine malformation is incomplete or deficient growth of the mullerian ducts. As a result there is the condition of absent uterus, the unicornate uterus, and finally the bicornate uterus with a rudimentary horn. This last type, another form of double uterus, results from growth of one duct and only partial or rudimentary growth of the other. The cavity of the accessory horn may or may not communicate with the canal of the more normal horn. It is an important type clinically.

Congenital atresia of the canal of the rudimentary horn of a double uterus may result in hematometra, a serious condition usually requiring a laparotomy for the removal of the rudimentary horn and sometimes the entire uterus.

Novak[1] states that "When the development of one duct is normal and the other very imperfect, varying degrees of rudimentary horn of such a bicornate uterus are produced, and these may assume much gynecological importance, not only because of the diagnostic problems which their presence may entail, but because of the fact that such rudimentary horns may become the seat of pregnancy."

Pregnancy in a rudimentary horn is very similar to ectopic gestation, and according to DeLee-Greenhill[2], rupture of the pregnant uterus is apt to occur about the middle of pregnancy. It is obvious that the deformity itself may become a potentially dangerous condition if pregnancy ensues.

Pregnancy has been known to occur, and proportionately often, in an incompletely developed horn the canal of which had no proven connection with the uterine canal. For these cases pregnancy must have followed external migration of the spermatozoa or of the fertilized ovum[3].

A statement by Graves[4] that "Double formation of the uterus, as a rule, has no special clinical significance unless there is atresia and hematometra" is generally conceded to be correct. One can live quite comfortably with almost any type of uterine malformation if this condition is not present and pregnancy is not an issue. That is why by far the largest number of cases remain undiscovered until some complication arises. Most gynecologists and obstetricians rarely see more than one or two abnormalities of the uterus even after years of practice.

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Deformities of the uterus may be accidentally discovered by pelvic examination; by the study of sterility with X-ray and the opaqua media; by a laparotomy for some unrelated abdominal pathology, or for a supposed tubal pregnancy which proves to be a ruptured pregnant rudimentary horn; occasionally too by a caesarean operation needed because of some interference with the normal course of labor. Necropsy has often disclosed these abnormalities, and surprisingly enough in women who have had uneventful and successful pregnancies and labors, without arousing during life the least suspicion of their anomalies.

Case History

On June 1st, 1944, the patient, a well developed girl of fourteen, while in class at school began to menstruate unexpectedly and profusely. Her dress became stained, and she obtained permission to go home. Her mother, alarmed, called her physician who sent her into the Rhode Island Hospital where she was seen by the writer.

Her family history was essentially negative. She had no brothers or sisters. There were no familial diseases.

Previously she had had scarlet fever and whooping-cough. Measles only recently. Pyelitis at the age of five when an i.v. urography was done. The findings were inconclusive.

Her menstrual periods began a year before at thirteen. For the first six months these occurred every two or three months and were scant. For the latter half of this first year periods were approximately every three weeks, with duration of seven days and amount about normal. She seldom had any pain.

The patient had undergone an attack of measles several weeks before entering the hospital, and only about 10 days before entrance had finished a seven day period which was accompanied for the first time by fairly marked lower abdominal pains and occasional dysuria. Because this pain continued, and because the intravenous urography of ten years before gave inconclusive results, another was done on May 26th, six days previously.

This later urography ". . . showed a normal functional response by the right kidney. This kidney was moderately hypertrophied. No function whatever was demonstrated by the left kidney. It is possible that we may be dealing with an absence of the left kidney."

The patient, typically feminine, was calm and co-operative. Heart and lungs were negative. Breasts were well developed. The abdomen was soft except in the lower portion above the symphysis. Here the patient showed moderate tenderness upon pressure. No mass was felt. The liver edge was at the costal margin. Kidneys were not felt. The vaginal discharge was very dark, thick and tarry-like. It had every appearance of retained menstrual blood. The hymen was intact.

Upon rectal examination the cervix and only part of the fundus could be felt. One derived the impression of hardness of the uterus. There was a feeling of fullness on the left side not apparent on the right. The adnexa could not be felt.

The vaginal flow gradually subsided along with the pain which was not severe. After three days there was only a very slight staining.

On account of the last urography report a cystoscopy was done while she was still in the hospital. With the cystoscope in place, and after prolonged search the left ureteral orifice could not be visualized. A No. 5 catheter passed readily to the pelvis of the right kidney. Indigocarmine i.v. appeared in three minutes from the catheter and concentrated very rapidly. There was no evidence of the dye in the bladder, for the left side, after 15 minutes.

At the time of discharge from the hospital the patient was known to possess only a right kidney. She also had had a menstrual episode which suggested atresia somewhere in the genital tract. These two facts pointed to the possibility of a uterine malformation being present. The diagnosis was only a conjecture and had to await further proof.

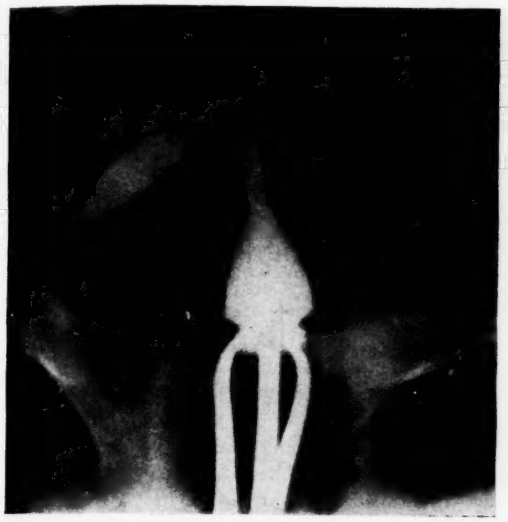
The patient took up her daily life again as any happy normal girl would. She returned to the office after long intervals but with no complaints. She was not much disturbed by her menstrual periods which came irregularly, sometimes every 30 to 31 days, and again every three or four months.

Less than three years later, early in 1947, the patient's mother came for prenatal care. Her pregnancy was uneventful until her 6th month, when she did not feel fetal life for more than a week. In July 1947 she spontaneously miscarried a 5½ months still-born fetus. These facts are stated because the fetus was congenitally deformed, without hands or feet,—a case of hereditary agenesis of the extremities.

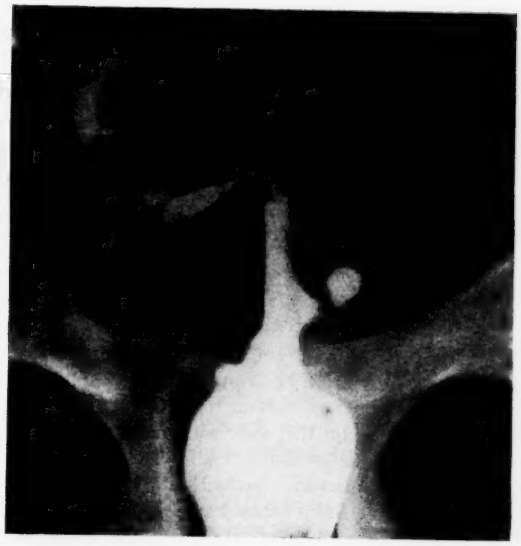
This would seem to strengthen the evidence, in the patient, of a possible congenital uterine anomaly, of the deficiency type.

The patient married in January, 1949, at the age of 19. Her menstrual period, after a lapse of several months, occurred two days before the wedding day, and lasted seven days. She came to the office about a month later, on February 15th. Contraception, at least for the present, was being practiced.

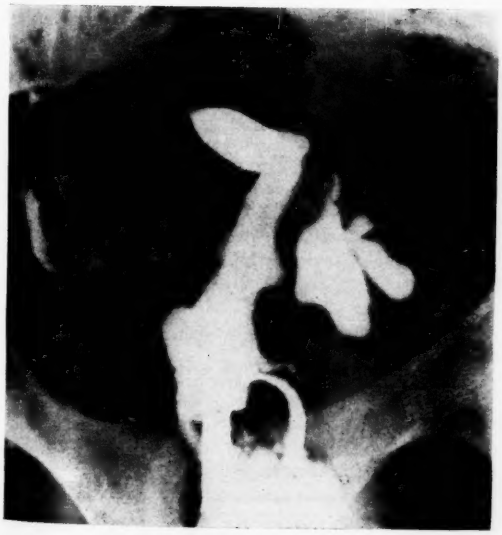
Upon bimanual examination the vagina readily admitted two fingers. There was a single cervix, rather large and without erosion. The fundus, anterior, felt somewhat irregular in shape, slightly large, and partly hard. The adnexa could not be felt. A probing sound was easily passed to the fundus, meeting with no obstruction. The uterine canal seemed somewhat longer than expected for a nulliparous uterus.



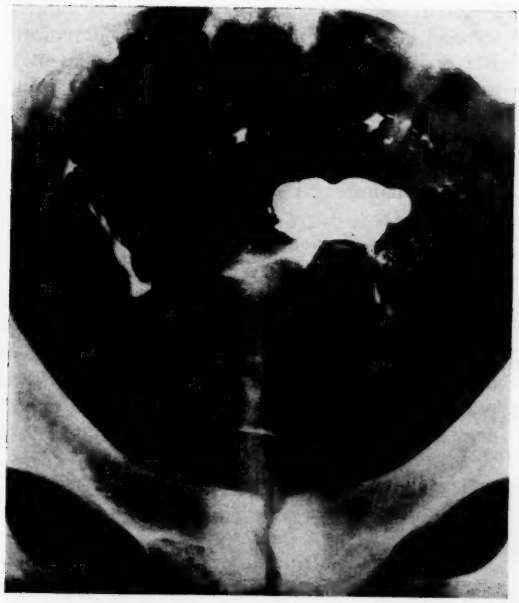
1. Right horn of uterus with patent tube. No left horn seen.



2. Note projection. Small left sac begins to fill.



3. Further filling of rudimentary horn.



4. Appearance next day, (20 hrs. later).

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At this time arrangements were made for a hysterosalpingography to be done several days after the cessation of her next period. This was done on April 11th, 1949, six days after her period ended, at the office of the roentgenologist*.

The patient was placed on the X-ray table in lithotomy position. After the usual cleansing of vagina and cervix, and the employment of sterile instruments, the cervical canal was injected with iodochlorol. A self-retaining cannula was used with a Jarcho tenaculum holding the anterior lip of the cervix. A 10 c.c. lok-syringe containing the iodochlorol was attached directly to the cannula. Under fluoroscopic control a number of spot films were made. Several of these are shown.

Injecting slowly, the cervical canal and the uterine cavity were promptly outlined, showing a somewhat widened cornua on the right side. The fallopian tube on this side was promptly entered, and the opaque medium readily spilled over into the peritoneal cavity. No outline of a left cornua was seen. For a brief moment it appeared that the very rare unicornate uterus, (with kidney agenesis), was present, as can be seen from the developed film. (Fig. 1)

But the advantage of fluoroscopic observation showed itself. After a moment or two a projection was noted arising from the left wall of the lower uterine canal.

The writer thereupon shortened the intrauterine length of the cannula above the rubber cone obturator and injected again with the remainder of the 10 c.c. of iodochlorol. A small round sac about ¼ to ½ an inch in diameter then appeared which seemed to connect with the uterine canal, first by a narrow area and then by the broad base of the projection mentioned at the lower left wall of the uterine canal. (Fig. 2)

A progressive further filling of the small pouch resulted eventually in the outline of an irregular sac which measured almost one inch in diameter. This is undoubtedly a rudimentary horn. (Fig. 3)

A film taken after removal of the instruments showed that the uterine canal, as well as the right cornua had emptied to a large extent. The irregular pouch on the left side was still filled more or less completely.

A film taken the next day, twenty hours later, still showed the opaque medium in the irregular sac, the remainder being scattered in the peritoneal cavity. (Fig. 4)

A final X-ray which was done 37 days later on May 19th was reported thus; "The previous collection noted in the left hemi-uterus, where there was a sac-like formation has apparently emptied completely."

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Comment

A uterine anomaly of the deficiency type, a bicornate uterus with a rudimentary horn, appears to be present. The fact that the rudimentary horn did not empty readily may be due to the narrowness of the bore of its canal, or to the undeveloped musculature of its walls.

Suspicion of the anomalous condition of the internal genital apparatus of a 14 year old girl was directed to it, first, by the disclosure of an absent kidney, and second, by the occurrence of a menstrual episode with passage of retained menstrual discharge and relief from abdominal pain. And indirectly, and later, by the mother's miscarriage of a fetus born with a form of agenesis.

The genital system should always be investigated if there is a known anomaly of the urinary organs, and the reverse statement holds as well.

Emphasis is made of the satisfactory results in most cases of diagnosing genito-urinary conditions by means of X-ray. Uterosalpingography, especially when spot films[5] are made of the fractional injections of the opaque medium under fluoroscopic control, is probably the best method today for diagnosing uterine structure.

Neither bimanual examination nor the use of the culdoscope[6], a valuable method for diagnosing pelvic pathology, can give the information regarding exact anatomical variation of structure as can be obtained by hysterosalpingography.

Summary

The report of a case of uterine malformation with kidney agenesis and a method for its diagnosis has been presented. The diagnosis of a uterine abnormality, especially of the type reported here, if made before complications arise, should result in better chances for the patient's safety.

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THALASSEMIA MINOR

A Report of Ten Cases

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RECENTLY we have observed ten individuals who were found to have the characteristic clinical findings which are associated with the diagnosis of Thalassemia Minor or Mediterranean anemia. Six of these were patients observed in the hospital. Two were sisters observed by one of us (H.L.) in private practice, the father of these girls, and the tenth was a brother of one of the hospitalized patients.

Cooley and Lee[1] in 1925 separated the classical form of the disease from the complex known as von Jaksch's disease. The classical form is characterized by hypochromic microcytic anemia, splenomegaly, typical facies and a racial and familial tendency. It is now known as Cooley's anemia, Mediterranean anemia or Thalassemia Major. Patients with this form of the disease usually do not live beyond puberty.

Since the description in 1940 by Wintrobe[2] and Damashek[3], a relatively milder form of the disease has been recognized and termed Thalassemia Minor. The clinical picture in these patients is that of hypochromia and microcytosis of the red blood cells with or without slight anemia and also occasionally associated with abnormally high red cell counts. Stippled, target and oval cells, quite out of proportion to the degree of anemia, are the morphological abnormalities seen in the red corpuscles. The resistance of the red blood cells to hemolysis in hypotonic saline solutions is increased. The anemia is refractory to iron therapy and the patient is usually of Mediterranean ancestry. Splenomegaly and slight icterus may be present.

The pathologic physiology involved is apparently an inherited defect in hemoglobin synthesis resulting in red blood cells which contain a little substance but adequate membrane so that they can absorb more fluid than normal cells[4] without bursting. Due to their thinness, they appear as the bizarre forms previously described.

Both the major and minor forms of the disease are inherited. The exact mechanism is not clear, but the inherited factor may be either an incomplete recessive or semidominant gene[5]. In a heterozygous individual Thalassemia Minor is produced. The homozygous individual suffers from the major form of the disease.

That the Mediterranean anemia syndrome is not of rare occurrence, is brought out by the survey in Rochester, New York[6] of persons of Italian descent in which the major form of the disease was present once in 2,368 births and the minor form once in each 25 persons. Other reports substantiate the frequent occurrence[7, 8].

Case Reports

CASE #1—C. S. was a 55-year-old Italian female who was admitted with vague abdominal pains and pains in both legs of one week's duration. She appeared well-developed and well-nourished, but pale. Physical examination was completely negative. There was no splenomegaly demonstrable. Her hemogram is shown in Table I. Decreased RBC fragility was demonstrated and a bone marrow aspiration revealed immature erythroblastic hyperplasia. Blood chemistries were within normal limits. No source of blood loss could be demonstrated.

CASE #2—E. S. was the 17-year-old son of C. S. who was admitted with a three-day history of pyrexia, chills, malaise, sore throat, sweating, nausea, vomiting and a harsh hacking cough. Physical findings were consistent with a right lower lobe pneumonitis of viroid etiology. This finding was confirmed by chest x-ray. The spleen was palpable at the costal margin. Sputum cultures were negative for acid fast bacillus. No evidence of blood loss could be demonstrated. Repeated hemograms revealed findings similar to those shown in Table I. His recovery was uneventful.

CASE #3—A. C. was a 76-year-old Italian male admitted to the Urological Service for suprapubic prostatectomy for benign prostatic hypertrophy. History was poor because of language barrier, but

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in addition to urinary symptoms he complained of weakness and vague abdominal distress over a prolonged period of time. There was no evidence of blood loss including a negative G.I. series. Physical examination revealed splenomegaly, the spleen being palpated at the costal margin. Repeated hemograms revealed persistent hypochromic microcytic polycythemia as shown in Table I.

CASE #4—E. M. was a 27-year-old white female of Italian extraction who was hospitalized for observation because of weakness and easy fatigue. Prior to admission she had been found to have a hypochromic anemia. Examination disclosed slight pallor of the skin and that the edge of the spleen was easily palpable at the costal margin. Work-up failed to disclose any pathology. This included x-rays of the gastrointestinal tract. Blood counts repeatedly showed hypochromic anemia. She has been followed for nine months since discharge with persistence of hypochromia despite iron therapy. Her latest hemogram showed 6.11 RBC, 10.6 grams hemoglobin, giving a color index of 0.58. Stained smears have persistently contained moderate poikilo- and anisocytosis with oval and target cells.

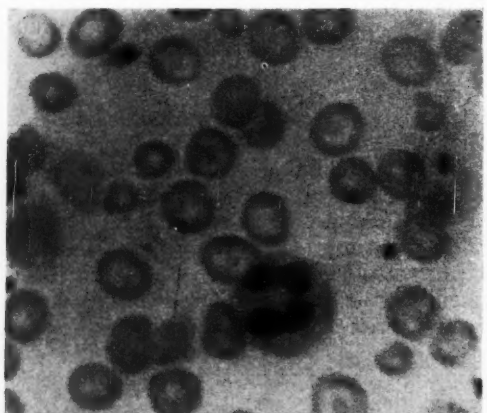

FIG. 1 Smear from Case No. 4 showing Target Cells, poikilocytosis and anisocytosis.

CASE #5—R. E. was a 29-year-old married sister of E. M. She had been in good general health and had no complaints. Examination revealed slight pallor of the skin and a palpable spleen at the costal margin. Report of hemogram is included in Table I.

A second sister of E. M. was examined and no abnormalities were found. Her blood count was 4.38 million RBC and 13.0 grams of hemoglobin, giving a color index of 1.0. Stained smear was in marked contrast to her sister's in that there were no target, oval or stippled cells and that the red blood cells were uniform in size and shape.

Table I

Patient	Rbc	Hgb	C.I.	Wbc	Smear	Spleen	Rbc Fragility
C.S.	5.76	11.0	0.65	8600	✗	0	Decreased
E.S.	8.70	15.0	0.59		✗	✗	
A.C.	7.12	10.0	0.48	7700	✗	✗	Decreased
E.M.	5.69	9.7	0.57	12000	✗	✗	
R.E.	6.01	11.0	0.61	8000	✗	✗	
A.P.	5.00	12.5	0.86		✗	0	
F.M.	5.90	13.0	0.63	6000	✗	0	Decreased
E.X.	6.95	14.0	0.66	5000	✗	✗	Decreased
A .Z.	4.80	11.4	0.79		✗	✗	Normal
S.B.	8.09	13.2	0.45	7100	✗	✗	Decreased

CASE #6—A. P. was a 50-year-old brother of C. S. who was in good health and whose hemogram was done at our request and is shown in Table I. Examination was completely negative.

CASE #7—F. M. was a 52-year-old Italian professional man, father of E. M., and R. E., who enjoyed excellent health except for occasional discomfort at the site of a previous thoractomy of his left chest for empyema. A complete hemogram was not done at the time of admission for this procedure thirteen years previously. He was examined presently, as well as his wife, to determine which one transmitted the trait. His hemogram is shown. That of the wife was entirely normal as was her RBC fragility. His spleen was not palpable through a somewhat obese abdomen. There was no history or present findings suggestive of blood loss.

CASE #8—E. X. This 55-year-old male native of Greece was known to have had bronchial asthma and unexplained splenomegaly since 1933. No record was obtainable pertaining to the hemogram at that time. Except for minimal pulmonary findings referable to his bronchial asthma and a definitely palpable spleen, his physical examination was essentially negative. There was no clinical or laboratory evidence of blood loss. His smear revealed moderate anisocytosis and a less marked degree of poikilocytosis. It was somewhat unusual for its very numerous tailed, pencil and other bizarre forms. Occasional stippling was seen and target cells were obvious. His hemogram recorded in Table I and smear were considered consistent with Cooley's trait.

CASE #9—A. Z. This 22-year-old Syrian male was admitted with a three-year history of recurrent attacks of RUQ pain and icterus. Eight months

prior to this admission he had a cholecystectomy for cholelithiasis and common duct stone. This procedure was done at another hospital and the composition of the stone could not be ascertained. Since his surgery, he had three attacks of colicky RUQ pain and icterus. He was admitted for investigation. Examination revealed a sallow complexion and the spleen one fingerbreadth below the costal margin. The liver was not palpable. The hemogram is shown. His smear revealed 4+ stippling, poikilocytosis and small oval cells but rare target cells present. There was no increased cellular resistance demonstrated. Liver function tests were all within normal limits. Serum bilirubin 3.4 milligrams. The urine was negative for bile and urobilinogen was positive in dilution 1:80. There was no clinical evidence of blood loss. Complete gastrointestinal roentgen series were negative and there was no evidence of common duct stone either by x-ray or duodenal drainage.

CASE #10—S. B. This 25-year-old Greek male was admitted for investigation of unexplained splenomegaly found on a routine physical examination. He had always enjoyed excellent health and systemic review was entirely negative. The only positive physical finding was a spleen palpable two fingerbreadths below the costal margin. His hemogram is shown. The differential was normal with no atypical cells observed. Moderately marked achromia was seen as well as occasional stippling. Red cell fragility was decreased. All other diagnostic procedures were negative.

Discussion

Ten cases of Thalassemia Minor are reported from the city of Providence. In view of the relatively large Mediterranean population particularly of Italian descent, it is to be expected that the disease is of common occurrence. Familiarity with the classical findings usually present in this disease will enable the physician to accurately diagnose patients presenting hypochromic anemia or polycythemia and otherwise unexplained splenomegaly.

The differential diagnosis includes anemia due to blood loss, lead poisoning, liver disease and other causes of splenomegaly.

Summary

Ten cases of Thalassemia Minor are described. The frequency of the syndrome is emphasized.

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THE PRACTICE OF MEDICINE IN THE FUTURE*

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This paper was prepared by the late Dr. John F. Kenney for presentation to the Bristol County Medical Association on March 21, 1950. Doctor Kenney died on March 20, and it is the wish of the Bristol County Medical Association, and of the Editorial Staff of the *Journal*, that the talk Dr. Kenney was to have delivered be published. — *The Editor.*

I HAVE chosen this subject because never in the history of medical practice, at least in this country, has there been so much talk and apprehension on the part of the public, the government and medical profession.

We hear names given to the future practice such as state medicine, socialized medicine, etc. Whatever the name given it—it is an established fact that the methods in the care of the sick are changing. A few examples: Blue Cross has been doing a successful job in paying hospital bills, and for a group, that we as physicians have been claiming were pinched in between. We have long maintained, and it is a fact that the wealthy could afford any hospital or diagnostic procedure, and the indigent obtain the same care free.

Any physician or nurse on a hospital staff will show you a chart of either of these two types of patients, filled with reports of consultations, and every laboratory and diagnostic procedure. The first group paid for it, and the latter received benefits of ward rounds, consultations, operations, etc., free or possibly part paid through a city grant, or otherwise, but in any case free insofar as the individual was concerned.

Now, the in between or middle class patient is coming into his own through Blue Cross and prepayment medical and surgical plans, for a sum, not too large per year, as compared to complete bills, doctor, hospital, and diagnosis, etc., rendered in the past. They are certainly small in regards to the high cost of hospital care at present.

*Prepared for presentation to the Bristol County Medical Association at its meeting at Warren, R. I., March 21, 1950.

Patients are becoming hospital conscious and demand entrance into hospitals due to a number of factors. Nursing care is important in carrying out doctor's orders, and it is impossible at present standards of living for a middle class patient, and certainly not an indigent patient, to afford a three nurse shift for very long without a severe dent in the bank account.

Then, again, people are living in smaller quarters, both apartments and small homes, where even isolation and proper care cannot be carried out. Then, the physician needs the various diagnostic procedures such as x-ray, E. K. G., metabolism or laboratory tests, typing, etc., even though after admitting a patient he may not use them. Rather than wait several days at home for symptoms to develop, that a diagnosis may be made clinically, he anticipates these procedures and many times by a quick and accurate diagnosis saves the patient a long illness or complication in a hospital, and perhaps saves a life.

Many physicians are clever at clinical diagnosis and perhaps their pre-practice training has been longer and better than some of their colleagues, but we all know that with the newer diagnoses and treatment and present medical school training the average doctor would be lost without laboratory facilities. This is one great complaint that the young trained doctor leaving medical school has against starting a country practice too far away from a medical center or good hospital facilities.

About Government Medicine

We hear Mr. Oscar Ewing tell about the advantages of government control of medicine and Governor Harold Stassen's admirable description of what it has led to in England in the short period it has been in force, but how often do you hear our own medical men evaluate what the government, national or state, have already under control? We will mention a few.

First, veterans hospitals take a large number of doctors to staff them, and they are controlled and under the pay of government.

In our own state, we have directors of various departments, such as child welfare, industrial medicine, a full time position as director of cancer, a bill recently put through for a full time medical

examiner, a rehabilitation director. We have full time residents at the state hospitals, as well as the directors of these various institutions. We have full time chest doctors either under state or local agency pay, and in the near future we can expect the possibility of heart and arthritic foundations, with full time staffs, and the possibility of other chronic diseases treated or controlled the same way.

So here we are gradually assuming a government controlled medicine in a different way but to my opinion the proper way. These agencies that I have mentioned all have high type men in not only the directorships, but in the subordinate positions as well; for example, the high standards set up for the medical staffs of the veterans hospitals. All this has a tendency to limit the field of general practice. The veterans run into the millions, and it will be only a short time when you will see the number markedly increased by the addition of veterans' families. So, if the government is not too hasty in putting over its socialized program, all they will have to do is wait a little longer and it will all be done for them.

The welfare program could not be started at this time because of the shortage of physicians. This shortage is still relatively acute, started during the last few years by first medical schools suddenly stopping the accelerated program, second, retention of medical men in the service, and taking into the various armed service hospitals of a large number of graduates that are kept out of civilian practice for some time. Third, most important, the establishment of residencies in hospitals, thus making it above five years after graduation from medical school before starting practice. Fourth, taking from private practice a number of physicians to staff the various V. A. hospitals and agencies.

There have been a few new medical schools started together with the existing medical schools increasing slightly the number in each class. These facts with what is happening in our own locality, that is, the addition of hospital beds at all hospitals, facilitating easier care, will eventually strike a balance where the patient load per doctor will equalize itself.

The problem of locating doctors in country practice is not of such import in Rhode Island but could be helped in many states where there is a shortage by subsidy, state or country building and maintaining small hospitals or diagnostic centers, a pooling of communities to accomplish this, but above all for the citizens of these areas to realize that to raise a family and give them what the families are obtaining, or have access to, in larger cities, has considerable to do with a doctor locating in these rural areas.

Specialty Boards

A few years back, the specialist in medicine or surgery frequently established himself by the fee he charged in excess of what the general practitioner received. The need for a change was recognized and the College of Surgeons and College of Physicians was started and standards and requirements for membership were set up after a founding body was taken in. This worked for a time but the specialists who strictly confined themselves to a limited field decided that something more drastic was needed and the various specialty boards came into being. There has been much criticism by the members who by reason of years in practice are regarded by other members of the profession as well qualified, who hold leading positions on the various hospital staffs, but for some reason or other will not take the examination, or for some technicality are not eligible.

The younger men are told by the professors in school to get out into general practice but the subjects given the students are all by specialists. In the recent war the specialists with board training received the best assignments. Even at our local level the hospitals are establishing residencies. Our largest hospital had over one hundred applicants for internes. Probably because each man felt it would put him in line for a residency when his interneship was completed.

Several hospital staffs have a rating committee that evaluate the various members of the staff and qualify him, only letting him do certain specialties and advance him in this field as he receives more training or demonstrates more proficiency. This overseeing by the staff, while it is an excellent thing, still has the young man aspiring for a specialist berth.

So, in conclusion—we hear that 80 per cent of the ills may be treated by a general practitioner and we now have an academy of general practice but changing conditions, Blue Cross, surgical plan, various agencies, and the demand in the past of the patient either going to a specialist direct or demanding that his physicians send him to one or to a clinic is gradually narrowing the field where the general practitioner may use his knowledge, no matter how well trained he is.

The public will have to be re-educated that the general practitioner can still treat the large percentage of ills, and hospitals will have to readjust the staff rules to make a place for these men, naturally keeping up the high standards and hoping that the government will recognize the high standards that the profession has set for itself both in and out of hospitals; subsidize certain areas if necessary but do not tear down or destroy the system of medicine that has given us the best health of any country in the world.

RESOLUTIONS *In Tribute To The Late* JOHN F. KENNEY, M.D.

President of the RHODE ISLAND MEDICAL SOCIETY, 1945-1946

RESOLUTION ADOPTED *by the* RHODE ISLAND GENERAL ASSEMBLY

WHEREAS, Upon Monday evening, March 20, 1950, there died John F. Kenney, M.D., a loss to the State of inestimable value because of his vast experience and public achievement, the General Assembly now records its tribute of appreciation for the valued contribution to official medical and public health records in Rhode Island.

Dr. Kenney was born January 5, 1890 in New Bedford. He graduated from Mosher Academy, New Bedford; from Tufts Medical School, *cum laude*, in 1913, and interned for 3 years at the Rhode Island Hospital.

In his crowded years, Dr. Kenney held many posts. Among them were these: President of the Rhode Island Medical Society; member of the advisory board and consultant at Memorial Hospital; founder of the Dr. John F. Kenney Tumor Clinic; also former chief of the medical department at Memorial Hospital and former laboratory chief; member of 2 State Boards in his field and consultant at 7 hospitals in this area; appointed to the committee investigating conditions at the state infirmary at Cranston; member of the basic science board of the state of Rhode Island and the advisory board of the Rhode Island curative center; former President of the industrial physicians and surgeons of New England; fellow in the American college of physicians; diplomat of the American board of internal medicine (Fellow in 1933) and a life member of the American Medical Association.

Dr. Kenney was a communicant of St. Mary's Church and a member of the Holy Name Society there. He was a member of Delaney Council, Fourth Degree, Knights of Columbus; now therefore be it

RESOLVED, That the members of the General Assembly, awed with the summary of the responsibilities indicated in these many high offices, now expresses its heartfelt appreciation for the calibre of this professional healer, whose indefatigable efforts to help mankind and conscientious devotion to duty have taken an early toll of his years; extending to the widow and family of the late John F. Kenney, M.D. sincere sympathy in their loss; directing the Secretary of State to transmit to them a duly certified copy of this resolution.

RESOLUTION ADOPTED *by the* COUNCIL *of the* NEW ENGLAND STATE MEDICAL SOCIETIES

WHEREAS Doctor John F. Kenney, of Pawtucket, Rhode Island, did invite the state medical societies of New England to send representatives to Providence, Rhode Island, on July 18, 1945, to consider the formation of a conference group to bring about a closer cooperation between the Societies in the development and maintenance of the highest standards in the conduct and the administration of medicine, and in the furtherance of plans to improve the health of all the people in the New England States, and

WHEREAS this meeting resulted in the formation of the Council of the New England State Medical Societies, of which Doctor Kenney served as its first vice president, therefore be it

RESOLVED that the members of the Council assembled for their fifth annual meeting this day, April 19, 1950, at Boston, Massachusetts, do record their deep appreciation for the pioneer work that Doctor Kenney did for the Council, and do extend to his widow and family their sincere sympathy in his untimely death on March 20, 1950.

The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society,
106 Francis Street, Providence, Rhode Island

MALPRACTICE EVIDENCE

MALPRACTICE has been defined by Regan as "the failure on the part of a physician or dentist properly to perform the duty which devolves upon him in his professional relation to his patient, a failure which results in some injury to the patient.

Thus, malpractice has two essential parts to it: first, that the physician fails to do his duty; and second, that definite injury to the patient is the result of his failure."

In elaborating on this definition with its twofold aspect Regan calls attention to the fact that this legal duty, arising as a matter of law out of the physician-patient relationship, requires "that the physician undertaking the care of patient possess and exercise that reasonable and ordinary degree of learning, skill, and care commonly possessed and exercised by reputable physicians practicing in the same locality, or in similar localities, in the care of similar cases; it requires also that the physician, in caring for the patient, exercise his best judgement at all times."

Medicine is not an exact science but is constantly changing in theory and practice. Sound induction of yesterday may well be obsolete and proved erroneous today. For example, successive editions of the same living author may well take different positions on the same subject and to allow an earlier opinion to be admitted as evidence would under these circumstances misrepresent the author's opinion on the subject.

Therefore, the action of the Senate Judiciary committee of the General Assembly is to be commended in not approving the act proposed to it last month to provide that a statement of fact or opinion on the subject of science or art contained in a published treatise, periodical, book, or pamphlet shall, in the discretion of the court, be admissible in actions of contract or tort for malpractice, error or mistake against physicians, surgeons, dentists, hospitals, and others.

Statements contained in medical books cannot be used in evidence, and counsel may not read to the jury from such books. This rule is subject to an exception as noted by Regan. When a witness refers to a treatise as corroborating his testimony, or bases his opinion thereon, the witness may be cross-examined as to the contents of the book. But if the physician testifying as an expert has not referred to any book, or named any book as an authority, or one on which he relied, it is not competent on cross-examination to go into the contents of medical books.

The statute proposed for Rhode Island would have imposed an extreme penalty upon the physician, dentist, optometrist or hospital. It would have deprived a defendant of an opportunity to cross-examine the author of the statement or opinion, thus making it impossible to test the accuracy and weight to be given such declaration. Since authors do not write under oath, the grounds of their belief

continued on next page

and process of reasoning could not be tested had the Rhode Island proposal been adopted.

Consider also the fact that extracts from medical books on the subject of science or art may be based on the unsworn statement of others beside the author, thus rendering such evidence of extremely dubious value. Consider the misinterpretation that might be effected, the resultant jury confusion, by the introduction of technical statements from scientific texts.

The incidence of malpractice in Rhode Island has been minimum. We are proud of the high standards maintained by our members. We have for many, many years had a committee on medical defense and grievance in the Society whose task it has been to hear complete testimony on any alleged error or malpractice charged against a physician, and to act honestly and impartially on the evidence presented.

We believe that our members endeavor to care for every patient with meticulous attention to the requirements of good medical practice. But we know that the physician may be sued unjustifiably by any patient despite anything and everything he may do. His defense is difficult enough without imposing such provisions against him as the use of opinions expressed in periodicals, books or pamphlets, as was proposed to the Assembly.

INSURANCE — AND THE COST OF GOVERNMENT

We have recently read annual statements from several large life insurance companies. Two interesting factors stand out in these reports. One is the tremendous growth of life insurance—with an estimate of eighty million policyholders in this country — and the second is that interest rates on investments continue to be low.

We in America have always been proud of the fact that the majority of us are thrifty, that we are willing to save from our current income through insurance in order to protect in some measure our individual futures. We certainly have reason to be concerned now that this incentive to save is being weakened generally by the continual increase in the cost of government.

Through the mechanism of the central banking system it has become the policy of the Government to keep interest rates low in order to borrow at as low a cost as possible the funds necessary to operate the tremendous ramifications of the government system, and to cope with the national debt. Thus interest rates cannot maintain the necessary balance between the supply of savings for investment and the demand for investment funds.

The Hoover Commission report put its finger on many of the faults of our expanded government activities which have siphoned off through taxes what might otherwise have been held by the individual as savings to be invested as he desired. The incentive to earn more, and to save, has thus been seriously weakened, and all the while increased government spending has lowered the purchasing power of money.

Eighty million people can't be wrong. But they can be fooled; only for a time, we sincerely hope. The invested savings of the people in insurance provided the capital that has created the industrial greatness of America which in turn has guaranteed work for the individual and reserve funds to protect adequately his life savings, whether in savings deposits or insurance.

The medical profession of this country has spearheaded a frank and open campaign of public education on the dangers inherent in the paternalism of government. The insurance industry has an obligation to take an equally aggressive position to bring forcefully to the attention of its eighty million policyholders the necessity for strict economy in every department of government, and the restriction of government within the confines of the legitimate duties for which it is established.

TUBERCULOSIS CONTROL

The annual report of the Providence Tuberculosis League is most encouraging to all engaged in the never ending battle against disease. Ten years ago there were 111 deaths from tuberculosis in the city of Providence. In 1948 there were 85, and last year there were 70.

The decline in mortality does not always indicate a decrease in the morbidity, as Dr. U. E. Zambarano, medical director of the League, has pointed out. The fight is not over, and there is still much tuberculosis that remains undiscovered and untreated. Control work goes forward, combating fear and ignorance on the way, and striving to bring the facilities available for diagnosis and treatment to the attention of everyone.

As Doctor Zambarano states in his annual report, "the most important factor in the control program in the future is the family physician." He will always be the first line of defense in all health activities, and his alertness will be the major factor in detecting tuberculous cases in the minimal stages.

PUBLIC LAWS

Ten years ago the General Assembly enacted the basic science law which in the intervening time has done much to raise the standard for licensure in Rhode Island for all who aspire to practice the healing art. The recent session of the Assembly was given a proposal that would result in a weakening of this law. That the Assembly would reject the proposal was to be expected by anyone appreciative of the importance of maintaining the highest possible standards for all physicians and dentists.

The amendments proposed would have allowed the candidate to receive less than 75% in two subjects, instead of one as now provided, would have eliminated examination of candidates in the laboratory should the board deem such tests necessary, and would have diluted the pre-professional academic education requirement by allowing the candidate to offer "educational qualifications equivalent thereto." Just what is equivalent to a year of pre-professional collegiate education in an academic college remains a mystery.

Instead of being weakened, the basic science law should be strengthened. In the light of present day practices and training it would seem that the pre-professional educational requirement might well be made two years instead of one.

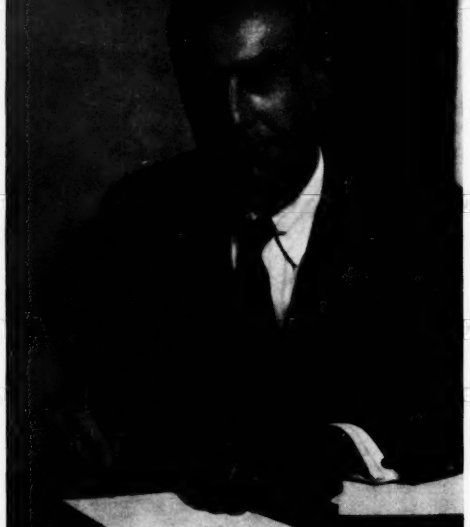
The enactment of amendments to the medical examiner law which do not carry out the recommendations of the special committee of the Society which gave much thought to the problems that arose as the result of the statute enacted a year ago, will hardly satisfy all who have been concerned. The joint committee of the bar association and the medical society served in the best interest of the state, and when their recommendations were only partially met a year ago it was readily apparent that the law would require further changes this session. The sub-committee of the Society, headed by the late Dr. John F. Kenney, offered what seemed a good solution to the problem, proposing utilization of the facilities of the Chapin hospital, and allowing the state medical examiner to be affiliated with that institution. The Assembly, however, has seen fit to solve the matter in its own way. We sincerely hope that the solution proves satisfactory.

THIRD GERBER ORATION

On April 19 there was held the Third Annual Isaac Gerber Oration under the auspices of the Miriam Hospital Association. Dr. Garlock of the Mount Sinai Hospital, New York City, gave a brilliant talk on surgery of the esophagus, a subject on which he is easily a leader.

There is no doubt that the startling and brilliant advances of surgery during the last few years have been mostly confined to the chest cavity. We say surgical advancements, but all these able surgeons point out that the advancements are due to the perfection of teamwork between themselves, internists, anesthetists, physiologists, and house and nursing staffs. It is a beautiful demonstration of what teamwork can do in medicine.

Probably these orations are not absolutely unique but it must be rare to have a living man so honored. Dr. Gerber accepts this distinction in a most graceful manner. We are looking forward to joining with him in many more of these delightful occasions.



CHARLES J. ASHWORTH, M.D.

of Providence, R. I.

President of the Rhode Island Medical Society

1950-51

PRESIDENT'S MESSAGE

A NEW PERSPECTIVE with its shift in values has been forced upon us following the recent war projecting responsibilities for the future no less than the present. Regardless of how objectively we try to present to ourselves the data of recent history, it is increasingly difficult to become separated from a point of view that must in the last resort be our own. This is not only natural but justifiable when scrutiny discloses that position to be evolved from truly Aesculapian tradition and set securely upon Hippocratic principles.

The seemingly insurmountable difficulties of a year ago have to a very great degree been leveled, but as we look forward again we see still other challenges that must be met and with equal success. This assurance stems from past accomplishment rather than from future hope. Persecution of our profession appears to be as necessary as pruning to an orchard, and no less effective. In the response that recent threats to the integrity of the art and the freedom of the practice of medicine have evoked, the profession has addressed itself to the task of integrating the economic, therapeutic, and social needs of our people.

Present day demands for interchange of social ideas have led to an increase of ideals which when put into action become motive forces with power directly proportional to the increase in knowledge resulting from such interchange. An effective ideal arises only from perception and recognition of a definite evil, and reform, not reaction, is the logical sequence, although different plans for reform may originate in the enthusiasm of an ideal. The common ideals of the present are the result of a gradual development to meet with existing evils, thereby planning a better future. While some of these are as old as civilization, others are due to forces which have come into existence only recently and the proper correctives must be developed in the light of this new and brief experience.

Observation of the success of contemporary efforts by groups not unlike the medical profession has revealed one underlying factor varying in degree but common to all. This has been unity. Personal differences, class distinctions, levels of rank, and other divisible components which tend to separate have been put aside for the purpose of securing a good objective. Individual sacrifice of both rights and privileges has resulted in a bond of strength, the force of which is measurable only by the accomplishment of the ends sought.

This unity which is so desirable in our ranks today and which has been achieved by others with a similar identity of purpose, is a simple notion but incapable of definition. That which is said to be one is undivided in itself. It is this undividedness which is so essential to the perpetuation of medical art cloaked as it is in the tradition of sacrifice and service to mankind. While we may be divided by many factors, racial, religious, material or political, we can as an organized profession rise above all these distinctions, now, as in the past.

Daily intimate contact with realistic problems may well obscure high ideals and noble purposes, but it becomes increasingly obvious that this unity of effort must not be lost sight of in the struggle against ignorance and prejudice.

Confronting us in the immediate future is the culmination of the first year of Rhode Island Medical Society's prepaid medical and surgical care plan so auspiciously begun under the direction of Physicians Service and merchandised by Rhode Island Blue Cross. The continued cooperation of each member of the state society will guarantee its success just as it has insured its beginning.

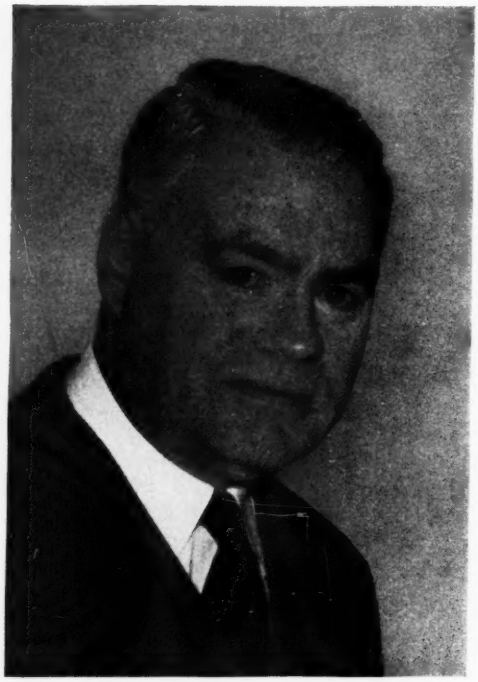
Similarly, the expansion of our public relations program will be a major item of accomplishment not only for the local improvement in a better understanding of our objectives with their inherent responsibilities to the public we serve, but also as a part of the national effort to extend in the needed areas the benefits of medicine's steady and ever increasing advances for the benefit of all.

The extension of better emergency coverage to other areas of the state which the operation of the new medical bureau in Providence has so ably demonstrated is possible, is another project which this year will demand and I know will receive the unity of purpose necessary for its complete success.

These then are but a few of the goals toward which our state society strives in this coming year. No word of exhortation is necessary to secure them other than to emphasize the meaning of and need for that concept of indivisibility connoted in the term unity.

May we emerge under the leadership of a new administration, confident in the determination to maintain unbroken the cherished traditions that have been exemplified so illustriously by all my able predecessors.

CHARLES J. ASHWORTH, M.D., *President*



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of Pawtucket, R. I.

Vice President, 1950-51

HERMAN A. LAWSON, M.D.

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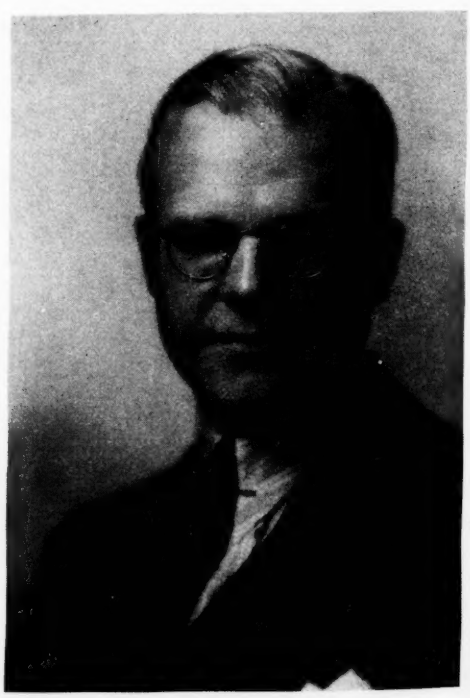

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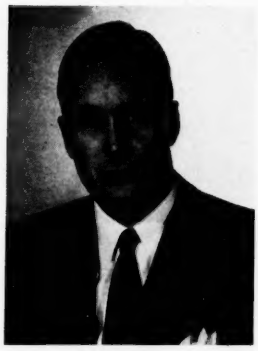

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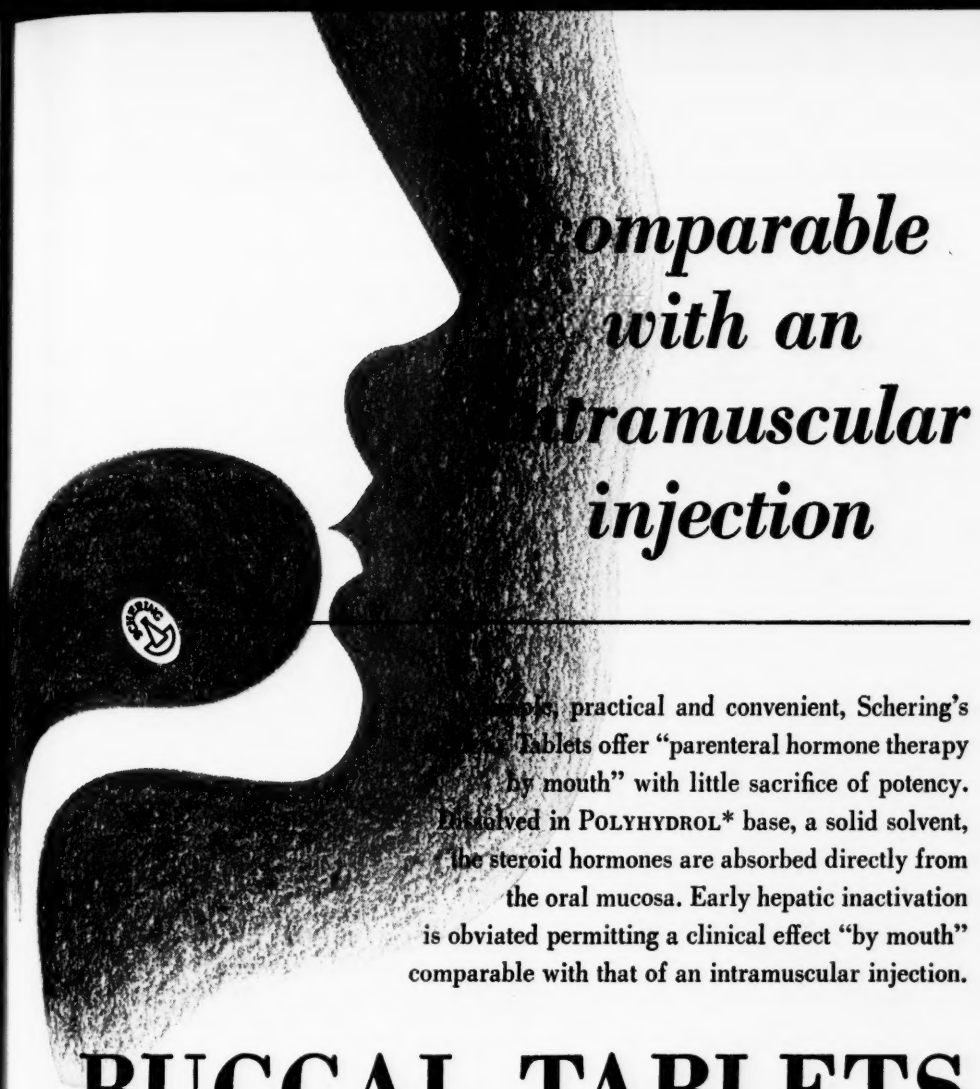

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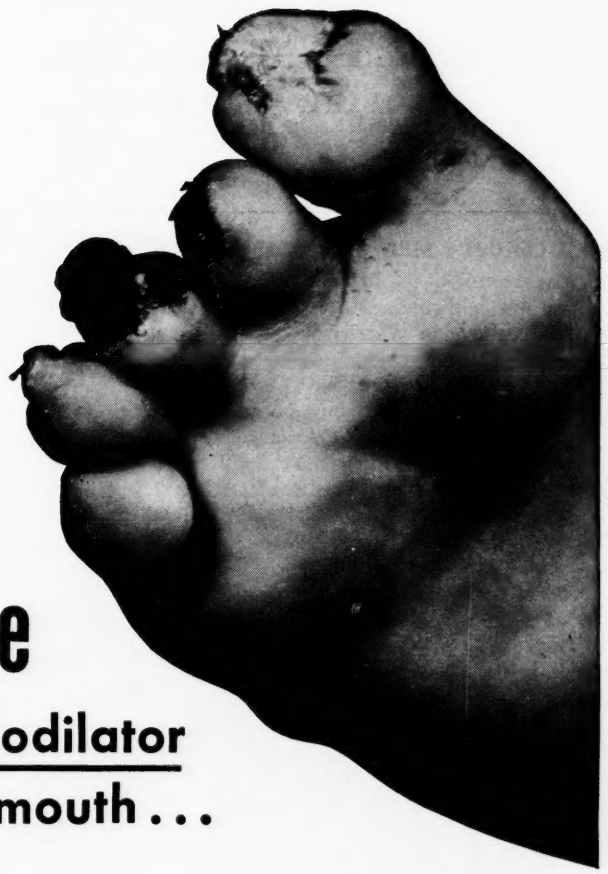

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Comprehensive literature on request.

1. Rogers, Max P.: J.A.M.A., May 21, 1949
2. Wyatt, Bernard L.: Ann. West. Med. & Surg., Aug. 1949
3. Grimson, Marzoni, Reardon & Hendrix: Ann. Surg., 127:5, May 1948

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DISTRICT MEDICAL SOCIETY MEETINGS

BRISTOL COUNTY MEDICAL ASSOCIATION

A regular meeting of the Bristol County Medical Association was held on Tuesday, March 21, 1950, at the Martin Home in Warren, Rhode Island.

The minutes of the previous meeting were read by the secretary and were approved as read. A few comments and explanations were necessary for those who did not attend the February meeting, when the subject of "Arthritis and the Use of Cortisone" was presented by Dr. Earl E. Hussey.

A report from the Department of Health, signed by Miss Catherine D. Tracy, R.N., Nursing Director, was read. The substance of this report was to the effect that Public Health nurses should not be allowed to give "certain potent drugs intramuscularly" without an order from the local doctor—"A Rhode Island licensed physician." The letter was filed.

A letter addressed to the president of the Association was presented proposing the establishment of a cardiac clinic in Bristol county for the benefit of children with rheumatic heart disease. At present the children coming under the State Rheumatic Fever Program have to travel by bus or car to one of the Providence Hospitals for their examinations and electrocardiographs. This service would be available to anyone up to 21 years of age who is referred by the local physician. The district nurse, Miss Tanner, reported that at present there are ten children being cared for, four from Barrington, and six from Warren. The letter was placed on file for future consideration.

Dr. Henry B. Fletcher reported that Dr. E. K. Landsteiner was going to attend a meeting for the study of Atomic Medicine at Rochester, New York, this week. He was to be a delegate from the Rhode Island Medical Society.

The various members reported that they have not yet received bills for their annual dues, and also that the treasurer has not paid some of the accounts outstanding. The secretary was informed to call this matter to his attention.

The subject of the March meeting was to be "The Practice of Medicine in the Future" and the speaker was to be Dr. John F. Kenney of Pawtucket, R. I., past president of the Rhode Island Medical Society. However, the night previous to the meeting, Dr. Kenney died. His manuscript which had been submitted to the Secretary of the Association the previous day was read by each member, and it was voted to present the manuscript to the Editor of the Rhode Island Medical Journal with the request that it be printed in that publication.

The meeting adjourned at 10:45 P. M.

Respectfully submitted,

ARCADIE GIURA, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kent County Medical Society was held on Tuesday, March 21 at the I. M. Gan Building, Post Road, Apponaug.

The meeting was called to order at 9:25 P. M. by Dr. Joseph C. Kent.

Application for membership into the Society was received from Dr. Ansalen Schurgast of 10 Herbert Street, Warwick, R. I. Application was signed by Dr. Charles Phillips and Dr. Fenwick Taggart. This application was referred to the Board of Censors for further action.

A letter was received from the State Health Department in regards to plans for a mass chest survey in the area of West Warwick. Motion was made by Dr. Wittig and seconded by Dr. Taggart that the Society go on record of approving this chest survey.

Following the regular business meeting the Director of the second fund raising campaign for the Kent County Memorial Hospital was introduced by the President. He stressed the need for workers in the campaign and emphasized the importance of having a complete coverage of residents of the entire County. He also told that there were approximately 2700 prospects that were not solicited during the first campaign.

An appeal was made to the members of the Society for individual contributions and not collective pledges.

Following this discussion it was decided to call a special meeting of the members on Tuesday, March 28th at 9:00 P. M. in order to take final action by the members for this second fund raising appeal.

Meeting adjourned at 10:35 P. M.

Respectfully submitted,

E. T. HACKMAN, M.D., *Secretary*

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PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held on Monday, April 3, 1950, at the Medical Library of the Rhode Island Medical Society. The meeting was called to order at 8:35 p. m. by Dr. Frank W. Dimmitt, Vice President, who presided in the absence of Dr. U. E. Zambarano, President.

With the approval of the members present the reading of the minutes of the previous meeting was omitted.

The secretary reported two communications. One was an invitation to the membership to attend the International Congress of Obstetrics and Gynecology, to be held in New York May 14-19. The other was from Dr. William H. Magill reporting office equipment that he has available for sale.

Dr. Dimmitt announced the appointment of the Association's committees to prepare tributes of the Association to deceased members:

To prepare the Association's tribute to the late Dr. Pearl Williams:

Dr. Herbert G. Partridge and Dr. Elihu S. Wing.

To prepare the Association's tribute to the late Dr. Alan E. O'Donnell:

Dr. Francis V. Corrigan and Dr. Frank A. Merlino.

To prepare the Association's tribute to the late Dr. Jacob S. Kelley.

Dr. Herbert H. Armington and Dr. William H. Foley.

Dr. Dimmitt called upon Dr. Stanley S. Sprague, Chairman of the Committee on Industrial Health of the Rhode Island Medical Society, to discuss the Rehabilitation Seminar to be held on April 12. Dr. Sprague briefly reported on the plans for the meeting and urged the members of the Providence Medical Association to attend.

The first guest speaker of the evening was Milos J. Lota, M.D., Haffenreffer Fellow in Medical Science, Brown University and R. I. Hospital; Formerly Professor of Physical Medicine at Charles University, Prague, Czechoslovakia, who spoke on "SOME NEW ASPECTS IN RADIATION THERAPY WITH SPECIAL CONSIDERATIONS ON THE PRACTICAL USE OF INFRARED AND ULTRAVIOLET IN CLINICAL MEDICINE."

Dr. Lota stated that psysiotherapy is one of the oldest types of medicine since it was used years ago. All electromagnetic waves travel at the same speed, 186,000 miles per second. Each kind of radiation can be determined by its wave lengths and frequency. Short waves vibrate at greater frequency. The standard unit for measuring wave lengths is the Armstrong unit. An Armstrong unit equals 0.1 millimicron (one micron equals 1/1000 of a millimeter).

Light projected thru a glass prism is dispersed in-

to a spectrum. Ultraviolet is at one end and infra red at the other. Only a small part of the electromagnetic spectrum is visible. We have in their order, radio waves (short waves) used in diathermy, infra red, solar rays, visible rays, ultra violet x-rays, gamma rays, and cosmic rays. The cosmic rays are the shortest.

Light consists of a bunch of photons. The smallest unit of matter is the atom,—the smallest unit of radiant energy is the photon, the size of which is proportionate to the frequency of the unit. The photon has a speed of 300,000 kilometers per second. This speed is maintained until it is stopped by a liquid or solid body. This body then contains activated molecules. An activated molecule causes more vibration of the molecule. Activated molecules exist only a short time, only a millionth of a second, when it passes to photosynthesis or degradation to heat. Rays penetrate all substances to some extent. Various layers of skin are transparent to various wave lengths. The intensity of the radiation varies with the square of the distance from the source. The intensity also varies with the cosine of the angle to the patient's body. Therefore always place the lamp so that the rays reach the patient at right angles for the maximum intensity.

Radiation penetrates the human skin differently according to the wave length. Visible rays have a higher absorption in the corium, ultra violet rays a large absorption in the malpighian layer.

Light sensitivity of skin is highest in spring and autumn. The sun is the most important source of infra red radiation. The incandescent lamp produces 95 per cent infra red rays. Infra red rays produce heat and erythema by stimulation of vasomotor mechanism. Deep erythema persists ten minutes to several hours after exposure.

The clinical uses of infra red rays produce muscle relaxation and relief of pain. Used in subacute to chronic inflammatory conditions, contusions, muscle sprains, synovitis, tenosynovitis, fractures, and arthritis. Infra red hyperemia makes the skin more susceptible to ultraviolet radiation causing a deeper penetration.

Contraindications to infra red radiation:

(1) Burns
(2) Poor circulation
(3) Apply with caution over old scars
(4) Do not use in fibrile cases

The second speaker was John L. Fromer, M.D., Member of the Staff, Allergy and Dermatology Service, the Lahey Clinic, Boston, who spoke on "MANAGEMENT OF COMMON SKIN DISEASES."

Dr. Fromer presented a classification of the eczema group of skin disorders. He listed the following groups:—seborrheic, hemostatic, (such as occur in varicose ulcer cases), intertrigo group,

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PROVIDENCE MEDICAL ASSOCIATION

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lichen simplex, and the dermatophytic group. In general the group is quite polymorphous.

Atopic dermatitis includes bakers and milkman's eczema. This is treated with diet, allergically denatured foods, dust proof environment, and topical treatment.

In infantile eczema, 41 per cent react to food, and 59 per cent to food and inhalants.

Contact dermatitis sensitization follows the law of serum sickness. You have contact, an incubation period, and re-contact with onset of symptoms. The same holds true with any industrial exposure.

He treats eczema with wet dressings and bland lotions. As it subsides he adds a bland cream. For general measures use a restricted diet, bed rest, antihistamine sedatives, I. V. procaine, and liver extract. In persistent acne he uses antogenous vaccines, staphloccus, toxoid, liver extract, vitamin A, and in older males stilbestrol. He advises against using local penicillin or sulfa drugs. Sycosis barbae he treats with penicillin generally and local application of ammoniated mercury. A saturated solution of sodium thiosulfate is used for taenia versicolor which is due to a fungus infection. He uses testosterone therapy for lupus erythematosis.

Since the skin normally has a p.h. of 4-5, fatty acids are very useful in prophylaxis against ringworm infection, e.g. caprilic acid, such as is found in desenex.

Attendance was 73. The Meeting adjourned at 10:40 p. m. Collation was served.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held on April 20, 1950, in the Nurses dining room of Memorial Hospital. This was a dinner meeting and fifteen members attended.

The meeting was called to order by the President, Dr. James P. Healey at 7:15 P. M. The minutes of the annual meeting were read and accepted.

The secretary reported on a letter from Dr. John G. Walsh announcing the meeting of the International and Fourth American Congress on Obstetrics and Gynecology, in New York, May 14-19, 1950.

A bulletin from Whitaker and Baxter including addresses delivered at the February Conference of the National Education Campaign was noted and its legal memoranda regarding participation in election campaigns.

There was also a letter from Dr. William L. Leet requesting one of our group to be a member of the

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By keeping the incompatibles apart,

You control the stability

YES, you're in complete control of the B complex injectable situation when you use BEJECTAL. This sterile preparation contains all five major vitamin B complex factors. As incompatible as they are, you control the stability for complete or partial use as needed. The chart tells you why. BEJECTAL is available through your usual source of supply in 10-cc. combination packages.

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Thiamine Hydrochloride	100 mg.
Riboflavin	20 mg.
Nicotinamide	750 mg.
Pyridoxine Hydrochloride	50 mg.
Calcium Pantothenate	50 mg.

In Water for Injection, U.S.P.

Benzyl Alcohol, 0.9%, is added as a preservative since the mixed solution is for multiple doses.

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This is the best way to prepare Bejectal when you expect to use the entire 10 cc. within 2 months. Simply withdraw 4 cc. of the contents from the small vial with a sterile syringe and transfer to the large vial. Shake the large vial and Bejectal is now ready for use.

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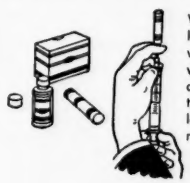

When you expect 10 cc. to last longer than 2 months, this is the best way to use Bejectal. For example, whenever you want to inject a 1-cc. dose, simply withdraw 0.4 cc. from the small vial and 0.6 cc. from the large vial. Unused portion in separate vials remains stable till needed.

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COMPONENT SOCIETIES BY MEDICAL DISTRICTS — 1950

SOCIETY	DELEGATES	COUNCILLOR	OFFICERS	MEETING
Kent County Medical Society	Rocco Abbate Peter Erinakes	Arthur Hardy	*President*, Joseph Kent *Vice Pres.*, Jean M. Maynard *Secretary*, Edmund Hackman *Treasurer*, John Mack	3rd or 4th Tuesday of each month
Newport County Medical Society	Frank Logler Donald B. Fletcher	Samuel Adelson	*President*, Henry W. Brownell *1st Vice Pres.*, Robert L. Bestoso *2nd Vice Pres.*, John M. Malone *Secretary*, Osmond Grimes *Treasurer*, Norbert U. Zielinski	4th Tuesday of every other month, starting September
Pawtucket Medical Association	Earl Mara Edward H. Trainor Henry Hanley Robert T. Henry Henry Turner	Charles L. Farrell	*President*, James P. Healey *Vice Pres.*, Kieran Hennessey *Secretary*, Hrad Zolmian *Treasurer*, Laurence A. Senseman	3rd Thursday of every month
Washington County Medical Society	Louis Morrone Samuel Nathans	John Paul Jones	*President*, Clifford Hathaway *1st Vice Pres.*, Thomas Nestor *2nd Vice Pres.*, Julianna R. Tatum *Secretary*, Samuel S. Farago *Treasurer*, Samuel S. Farago	2nd Wednesday of every 3 months, starting October
Bristol County Medical Association	John A. Mellone	Paul C. Bruno	*President*, Ralph J. Petrucci *Vice Pres.*, Hubert Holdsworth *Secretary*, Arcadie Giura *Treasurer*, Antonio DiAngelo	3rd Tuesday of each month
Woonsocket Medical Society	George Keegan Joseph McKenna	T. J. Lalor	*President*, Leo Dugas *Vice Pres.*, Alfred King *Secretary*, Emil Kaskiw *Treasurer*, Paul Boucher	No fixed date
Providence Medical Association	Robert Baldridge J. Murray Beardsley Peter Pineo Chase E. Victor Conrad Frank B. Cutts William P. Davis Donald DeNyse John Dillon	Albert H. Jackvony	*President*, Ubaldo E. Zambarano *Vice Pres.*, Frank W. Dimmitt *Secretary*, Daniel V. Troppoli *Treasurer*, J. Murray Beardsley	1st Monday of every month; Oct.—May inclusive
		William J. H. Fischer David Freedman Herman Grossman Peter Harrington William Horan Russell Hunt	Louis I. Kramer Herman A. Lawson Edward McLaughlin Robert Murphy John C. Myrick Joseph C. O'Connell	Michael O'Connor Edwin O'Reilly Alfred Potter Louis Sage Daniel Troppoli George Waterman

SOCIETY	OFFICERS	ANNUAL MEETING	CHAIRMAN, STANDING COMMITTEES	
Rhode Island Medical Society 1950-1951	*President*, Charles J. Ashworth *Vice Pres.*, Robert T. Henry *Pres. Elect*, Herman A. Lawson *Secretary*, Morgan Cutts *Treasurer*, Earl F. Kelly *Ass't. Treas.*, John Dillon	May 9 & 10, 1951 at Rhode Island Medical Society Library, 106 Francis Street Providence 3, R. I.	Joseph C. O'Connell Charles L. Farrell James H. Fagan Marshall Fulton Nathan Chaset Stanley Sprague Herbert G. Partridge John E. Donley Edgar S. Potter & Albert H. Jackvony	Scientific Work and Annual Meeting Public Policy and Relations Public Laws Postgraduate Education Medical Economics Industrial Health Library Publications Auditors

Florence M. Ross, M.D., Providence
William B. O'Brien, M.D., Wallum Lake
Thomas H. Murphy, M.D., Providence
Herbert F. Hager, M.D., Providence

Committee on Relations with the Veterans Administration

Herman A. Lawson, M.D., *Chairman,* Providence
Francis H. Chafee, M.D., Providence
James P. Londergan, M.D., Providence
Kenneth Burton, M.D., Providence
Hilary Connor, M.D., Providence
Hartford P. Gongaware, M.D., Westerly
Robert Henry, M.D., Pawtucket
Earl J. Mara, M.D., Pawtucket

Committee on Vocational Rehabilitation

Vincent J. Ryan, M.D., *Chairman,* Providence
Henry J. Hanley, M.D., Pawtucket
Albert H. Jackvony, M.D., Providence
Robert H. Whitmarsh, M.D., Providence
Herbert E. Harris, M.D., Providence
Emanuel Benjamin, M.D., Providence
William M. Muncy, M.D., Providence
James P. Deery, M.D., Providence

PAWTUCKET MEDICAL ASSOCIATION

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Nutrition Committee of the R. I. Medical Society to be organized by him.

A communication from the Committee on Public Laws of the R. I. Medical Society was reported on. It reviewed proposed laws before the R. I. General Assembly to which opposition has been voiced by the committee. Emphasis is placed on House 835 which would lower basic science requirements, and Senate 301 which would make admissible as evidence in malpractice actions statements of fact or opinion from treatises, periodicals, books, or pamphlets.

Motion was made and passed that a letter be sent to the Committee on Public Laws informing it of our resolution endorsing its action.

The meeting then retired to the Nurses Auditorium to hear Dr. Charles E. Millard, President, R. I. Chapter, American Academy of General Practice, speak on, "Problems of the General Practitioner and Their Solution." Complaints of general practitioners were presented and also recommendations as to specialist-general practitioner relationships and staff privileges. Raising the standards of general practice and the physician-patient relationship with restoration of the general practitioner to his old place of importance was urged.

Application forms for the American Academy of General Practice were distributed. The meeting adjourned at 9:00 P. M.

Respectfully submitted,
HRAD ZOLMIAN, M.D., *Secretary*

BOOK REVIEWS

HANDBOOK OF MEDICAL MANAGEMENT by Milton Chatton, Sheldon Margen and Henry B. Brainerd. University Medical Publishers, Palo Alto, California, 1949, $3.00.

This pocket size *Handbook of Medical Management* is designed primarily as a ready reference for the medical student and practitioner, and endeavors to provide essentials of modern methods of treatment to be used after the establishment of a diagnosis. It consists of 453 paper bound pages divided into twenty chapters and appendix plus an excellent index. The contents are arranged in outline form under the various chapter headings. The nomenclature follows that of the *Standard Nomenclature of Disease and of Operations* of the American Medical Association and includes the use of the code numbers. The names of chemicals and medicines mentioned are usually accepted drugs of the U.S.P., N.F., and N.N.R. Where proprietary preparations have been found to be in general use or of especial importance their use has been mentioned. Dosages are expressed in both the metric and apothecary systems.

The first three chapters are concerned with the general aspects of treatment and with dietetics. The activity status of the patient is considered for various general groups of diseases and recommendations for the degree of bed rest and for the use of the various bed positions, with simple sketches of the latter are made. The notes on patient environment and home management should be useful in discussing these subjects with those responsible for the care of the patient. A review of the clinical observations to be made by the physician is offered. The chapter of symptomatic treatment considers pyrexia, pain, shock, asthenia, anorexia, insomnia, weight and psychotherapy, with particular emphasis on the treatment of shock and the alleviation of pain. Caloric tables, sample diets, and types of diets followed by a brief review of the individual vitamins and fluid balance completes the general discussion of therapy.

Throughout the book frequent use is made of tables which provide a quick comparison of diagnostic features, dosage schedules, or comparative treatments as the case may be. Thirteen pages of the chapter on dermatology are devoted to tables giving types of skin disease, the methods of treatments of choice at various stages of the disease, strengths and forms of medicaments, and special prescriptions; in themselves, an excellent outline of dermatological therapy. Other tables, while not as complete nor elaborate, are well constructed and usable.

The remaining chapters consider various diseases on a symptomatic or etiological basis. Emphasis is on treatment, though, in the more complicated conditions where diagnosis may be difficult attention is given to the more salient points. Thus, the differential diagnosis of peripheral vascular diseases, the leukemias, liver disease, arthritis, cardiac disease and some others are considered at some length. While more space is devoted to the commoner and more complicated diseases and treatments the subject material is surprisingly complete. Where completeness is lacking there are sufficient notes to prompt the physician to look to the standard texts for detailed information and to guide him to the most helpful sections quickly, and to serve as a guide for the immediate care of the patient.

It is the intention of the authors and the publisher to print an annual edition to maintain the usefulness of the work. The book can be recommended to the practitioner as one to be carried with him as an outline of treatment, as an aid in bringing prompt use of therapeutic methods and medicines to the benefit of the patient, and as a reminder of available techniques and drugs to the physician.

A. LLOYD LAGERQUIST, M.D.

HUMAN GROWTH by Lester F. Beck. Harcourt, Brace and Company, N. Y. 1949. $2.00.

HUMAN GROWTH contains the same subject matter and pictures as the much discussed film of the same name. It gives the biological facts of human conception, fetal growth, birth, and development of the body and sex glands though adolescence to adult-hood.

The book is divided into four chapters. Following each chapter are questions and answers — questions which any normal, inquisitive child usually asks.

Chapter I describes the steps in the growth of a baby, and compares the growth of the boy and girl. Various glands control growth and other body functions.

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BOOK REVIEWS

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Chapter II describes and gives diagrammatic pictures of the sex glands and the male and female reproductive cells — sperm and ova.

Chapter III, called "Preview to Parenthood", gives the process of fertilization and division of the fertilized ovum into many cells — and finally a baby.

Chapter IV is entitled "The Miracle of Birth." The embryo or fetus is described at various stages of growth. Words and diagrams portray how a baby is born.

This small, compact book is very good for acquainting young people with actual biologic facts but deals not at all (no doubt intentionally) with problems which may arise in discussions (such as petting, masturbation, venereal diseases, etc.).

Highly recommended for teachers, parents and growing boys and girls.

MERLE MOSIER POTTER, M.D.

CLINICAL PATHOLOGY—APPLICATION AND INTERPRETATION. By Benjamin B. Wells, M.D., Ph.D., Professor of Medicine, University of Arkansas School of Medicine, Little Rock, Arkansas. W. B. Saunders Company, 1950.

There are numerous laboratory books dealing in great detail with the technical procedures of the various tests and in varying degree with their interpretation. These, for the most part, are of especial interest for the clinical pathologist, medical student, or for the unusually studious medical man. What has been lacking has been a book which is free of frills and furnishes the reader with sufficient background of the why and wherefore of certain laboratory tests indicated in a suspected disease process and a brief interpretation of the significance of the results. Wells' book, "Clinical Pathology — Application and Interpretation," does this very nicely.

The author has arranged the material in the book in the manner in which a physician may practically use it. "Beginning with a clinical situation, the applicable laboratory procedures are selected and their contributions to the problem are discussed with just enough theory and methodology to convey proper meaning and purpose." The book, arranged in nine chapters, deals with the application of clinical pathologic methods to infectious diseases, diseases of gastro-intestinal system, diseases of the respiratory system, diseases of the kidney and urinary tract, diseases of the blood, diseases of the cardiovascular system and metabolic and endocrine disorders.

The author has personalized the interpretation and evaluation of various laboratory procedures so that the book is easily readable and informative.

Although one might criticize the lack of greater detail in discussion of acid-base balance, this may properly belong to a monograph on the subject or one of the larger tomes on laboratory interpretations.

A quotation from the author's introductory considerations gives an insight to the author's approach to laboratory medicine: "We must constantly be aware of the fact that laboratory results are only one aspect of the total clinical observation. Seldom, if ever, are these tests subject to valid interpretation except as they pertain to all other manifestations which characterize the normal or abnormal state of the patient. Insufficient or improper use of the laboratory is most often an evidence of ignorance; excessive reliance on laboratory results is proof of inexperience."

The reviewer is favorably impressed with the book and would recommend it to all practicing physicians, interns, and medical students.

HERBERT FANGER, M.D.

SEXUAL DEVIATIONS, A Psychodynamic Approach by Louis S. London, M.D., and Frank S. Caprio, M.D. The Linacre Press, Inc., Washington 6, D. C., 1950. $10.00

There appears to be recently an increasing interest, or better, an accentuation of our interest, in matters pertaining to sex. Some of the latest publications have approached this ever-intriguing question from social, zoological, medical, and anthropological points of view. Our daily and popular press always carries at least one article pertaining to sex education, sex morals, sex crimes, etc.

It is timely, therefore, that this new book undertakes to describe, analyze, and offer a psychological explanation of the most puzzling aspect of sex, namely, the perversion of sex impulse, or sexual deviations. Both of the authors of this book are practicing psychoanalysts. The material comprising the greatest part of this book (Part II, over 600 pages) consists of case histories of patients treated by the authors in their private practice of psychoanalysis. Hence the "psychodynamic approach" or a method of psychiatric interpretation based predominantly on ideas and theories of Sigmund Freud and those of Stekel is thus illustrated.

Part I opens with a foreword by Dr. Nolan D. C. Lewis and a brief historical survey of the literature on the subject. A brief chapter on the development of the sexual impulses in the child follows. A short chapter on the theoretical considerations on deviation of sexual impulses in the adult concludes this part. These two chapters are intended to supply the basis and the theoretical foundation for the understanding of the case histories that follow. The case histories are in a sense real multidimensional portraits of the deviates and present an amazing collection of appropriate psycho-

continued on inside back cover

VITAL STATISTICS — 1949

DEPARTMENT OF HEALTH, CITY OF PROVIDENCE

I hereby present the preliminary report of Vital Statistics and Health Department Activities for the year 1949.

The 3058 deaths was the smallest number of deaths listed in the City of Providence since the year 1898 when 2928 deaths were reported. In this City the next smallest number was 3068 in 1934. There has been a slight increase in the deaths from Heart Disease. It is interesting to note that deaths from Nephritis and Cerebral Hemorrhage have decreased. It is also gratifying to note that deaths from Cancer have decreased. Pneumonia deaths are showing a continuous drop and this is the smallest number of deaths recorded in any one year since the Civil War.

Our Infant Mortality rate is the lowest ever recorded as is our crude death rate. The Birth rate 38.19 has been exceeded only in the years 1946-47-48.

It is interesting to note that our Communicable Disease record has also been very satisfactory with the lowest number of deaths from Pulmonary Tuberculosis reported in a single year.

While 1949 was a Measles year with 3254 cases reported, there was no death of a Providence resident attributed to this disease. Only 2 cases of Diphtheria were reported during the year.

Our Immunization Program has been proceeding very satisfactorily. Although the number immunized at the City Clinics are small, most every child in the City has been properly vaccinated and immunized, the majority by their own family physician.

On the whole the Health situation in the City is very satisfactory.

JOSEPH SMITH, M.D.
Superintendent of Health

Preliminary Report of Health Department Statistics — 1949

	1949	1948	1947
VITAL STATISTICS			
Deaths all	3058	3194	3270
Deaths under 1	227	235	281
Deaths over 70	1178	1274	1246
Births	10160	10341	11190
Marriages	2554	3257	3525
Infant Mortality	21.35	22.62	25.11
Death Rate	11.50	12.00	12.29
Birth Rate	38.19	38.87	42.06
PRINCIPAL CAUSES			
1. Heart Disease	1184	1167	1143
2. Cancer	483	491	486
3. Pneumonia	71	85	106
4. Nephritis	134	143	179
5. Cerebral Hemorrhage	154	211	201
6. Auto Accidents	25	30	40
MILK DEPARTMENT			
No. Samples Tested	15628	17016	17686
No. Licenses Issued	1584	1513	1464
PHYSICIANS			
No. Visits to Sick Poor	436	302	309

	1949	1948	1947
DIPHTHERIA IMMUNIZATION			
No. Schick Tests	8732	7557	7879
No. Alum Toxoid Treat.	109	3975	4538
No. Tri-Immunol Treat.	736		
No. Diph. Tox. Prot. Prec.	3354		
SMALLPOX IMMUNIZATION			
No. Vaccinated	1442	1606	1684
INSPECTORS			
Food Inspector:			
Inspections	10456	7897	7190
Licenses Renewed	306	3921	1940
New Licenses	1300	258	215
Transfers	137	152	177
Licenses Withdrawn	2	1	2
Liquor Lic. Transfers	3		
Licenses Not Approved	9	11	17
Sunday Sales Trans.	8		
Lunch Cart Licenses	3	3	3
Sunday Sales Renewed	378		
Liquor Lic. Renewed	530		
Sanitary Division:			
No. of Visits	8602	8289	6795
Animal Bite Visits	2166	2018	1816
Kennel Lic. Approved	28	29	39
Garbage Lic. Approved	30	18	19
NURSING VISITS			
Communicable Diseases	5114	2772	6775
Parochial Schools	5571	4272	3890
Tuberculosis-Home	8970	9991	9022

COMMUNICABLE DISEASES	CASES				*DEATHS*			
	1949		1948		1949		1948	
	Res.	Non Res.	Res.	Non Res.	Res.	Non Res.	Res.	Non Res.
Diphtheria	2	1	3	2	0	0	1	0
Scarlet Fever	134	61	194	41	0	0	0	1
Measles	3254	60	244	17	0	1	0	1
Whooping Cough	200	11	160	15	2	0	0	0
Pulmonary Tuberculosis	204		244		24	13	42	10
Septic Sore Throat	1	0	0	0	0	0	1	0
Strep Sore Throat	12	0	9	1	0	0	0	0
Gastro Enteritis	39	9	34	14	5	2	6	3
Bacillary Dysentery	6	0	7	2	0	0	1	0
Poliomyelitis	50	120	1	7	0	0	0	0
Epidemic Meningitis	6	4	4	8	3	0	0	1
Typhoid Fever	0	2	5	0	0	0	0	0
Paratyphoid Fever	3	0	4	2	0	0	0	0

*Includes Non-Residents

BOOK REVIEWS

concluded from page 271

pathological material. The case histories include the family history and setting, psychosexual development, traumatic incidents, various indulgencies and deviations of the patient. These are concluded by dream analyses, interpretation of psychodynamics, and a so-called epilogue, usually indicating that patients have been relieved of their deviations by the appropriate treatment, i.e., psychoanalysis. Part III of the book concerns itself with: psychosomatic ailments associated with sexual pathology, an interesting chapter on medicolegal management of sex offenders, a glossary of terms, and a bibliography.

I feel that the plan of this book is an ambitious one, but in executing it the authors were not able to avoid many of the pitfalls inherent in such an undertaking. There is no doubt that a sound understanding of the sexual deviates and their mental processes is imperative for doctors, lawyers, educators, and social workers because of the nature of their work. However, for those who have little or no psychiatric experience, this book may be rather confusing. The chapters on the sexual impulses of the child and deviations in the adult are certainly not a sufficient preparation for the reading public not versed in psychoanalytic theory or philosophy. There is also the danger that the use of psychoanalytic terminology will be accepted by many and used with the ease and facility of a jargon without the understanding of the real meaning and value of the terms. On the other hand, to a number of experienced therapists, well grounded in psychodynamic principles, this book might be of limited interest only. It is also my feeling that the medical students and beginners in psychiatry who will read this book before they have had a sufficient amount of actual experience in dealing with deviates, will obtain easy formula-like answers and this may impair their personal appreciation of actual psychopathology in individual cases. Some of the material in the case histories is repetitious and poorly organized from a chronological viewpoint. There is also a certain looseness and uneveness of style, as for example:

"Sadism is turned into masochism as the result of consciousness of guilt. Stekel has shown the relationship of sadism to homosexuality, whether it be male or female. In masochism, the sadism is directed against the person himself. This is the result of guilt through moral and religious influences of childhood." (Page 245). And again,

"Epilogue: One year after the analysis ceased, the patient reported that she met a Major who said that she was the most passionate woman he had ever met. This was fourteen years ago. Nothing has been heard of her since." (Page 245)

I agree with the authors that this work is rather "a beginning — not an ending". This book contains a vast amount of interesting material to be carefully appraised and digested. The work of the authors is that of pioneers and as such should be appreciated.

SIDNEY S. GOLDSTEIN, M.D.

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